Approved 2-19-85
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Senatory Roy M. Ehrlich at
Chairperson

10:00 a.m./~~p.m.~~ on February 12, 1985 in room _____ of the Capitol.

All members were present except:

Committee staff present:

Conferees appearing before the committee:

Deborah Hinnen, RNMN, President, American Diabetes Association
Martin Toews, Regional Field Director for ADA
Milly Johns, President-Elect of American Diabetes Association, Kansas Affiliate
Richard Guthrie, M.D., Wichita
Walt Whalen, Vice-President, Pyramid Life Insurance Co., Johnson County

Others Attending: See Attached List

The motion was made by Senator Francisco and seconded by Senator D. Kerr that the minutes of February 4, 5, 6, 7, and 8, 1985, be approved. Motion carried.

SB-121 - Mandatory health insurance risk sharing plan

Deborah Hinnen, RNMN, testified and presented written testimony supporting SB-121. She stated that the person with diabetes deserves the right to reasonably priced health insurance as do other productive citizens.

Martin Toews, appeared in support of SB-121 and waived his time to Richard Guthrie, M.D.

Millie Johns testified and presented written testimony supporting SB-121. Mrs. Johns shared a number of instances where insurance difficulties had arisen.

Richard Guthrie, M.D. testified and presented written testimony supporting SB-121, stating that having insurance will facilitate quality care that reduces health care insurance costs. Such coverage will reduce the number of persons on Medicaid and reduce the state's health care costs.

Walt Whalen testified opposing SB-121. Mr. Whalen stated that he would submit written testimony for the committee. Mr. Whalen cited two groups, one who could afford insurance and those who can afford it and cannot get it. The company he represents does insure diabetics, sometimes at an increased rate and reduced benefits. He further stated that if there is a need and if the population is there to support that need the insurance industry provides coverage. The industry does not feel any demonstration of need of this type of coverage within an affordable range has been shown, and further stated if there is a social need it should be funded through society.

Hearings will be continued on Friday, February 15, 1985.

Meeting adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-12-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Jim Yonally	United Way
JACK ROBERTS	BC-BS
Tom Bell	Ks. Hosp. Assn.
Harold Pitts	FARTA
Ruth Wilkin	AAUP -
JERRY SLAUGHTER	KNS
LARRY MAGILL	IIAK
Ronald Kayser	KDOA
Marilyn Bradt	WINH
Sharon Leatherman	KHCA
Jim Klausmeier	KHCA
Frances Kastner	KFDA
Michael Woo IC	Intern - Sen. Morris
Gracie Matthews	Sen. Walker office
Lew Jen Schneide	KID
Jeremy Linscheid	
Robert G. Anderson	Self
Rod Lake	KASB
Ken Schafermeyer	KS. Pharmacists Assoc.
Julia Francisco	
Marilyn Mainey	
Walter Werhahn	Pyramid Life Ins Co
David Hanson	Ks Life Ins. Assoc

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 2-12-85

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Allen Cox Lawrence	Intern - Sen. Karr
Carl Schmitthenner	Ks Dental Assn.
Richard A. Guthrie MD	Ks Diabetes Assn
Martin Jönus	Am Diabetes Assn
Milly Johns	am Diabetes Assn-Ks.
Belinda Childs	Am Diabetes Assoc. - Ks
Deborah Hinner	Am. Diabetes Assoc. - Ks.
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS

Deborah Hewins — 2-12-85 —

Tuesday, Feb. 12, 1985
re: Senate Bill 121
Notes For: Committee on Public Health and Welfare

Senators,

As President of the American Diabetes Association - Kansas Affiliate and a member of the National Board of Directors, I can convey to you that these organizations are most supportive of the concept of Senate Bill no. 121.

Indeed the American Diabetes Association is ecstatic that pooled risk health insurance is being proposed in the legislative arena. Pooled risk insurance has been enacted in only a handful of other states. Kansas' consideration and hopeful passage of SB121 will maintain our position in a leadership role for health care.

As a nurse, I can share with you how hard people work to control their diabetes to try and prevent hospitalization and other health costs. Those people without insurance must work twice as hard to self manage their diabetes because, a slip or mistake on their part can mean hospitalization without the reassurance of any financial support in paying those bills. Daily supplies cannot be eliminated or reduced for the person regardless of insurance availability.

The cost of supplies varies widely. A sample of Wichita prices for Feb. 11, 1985 are as follows:

Human Insulin $12.40 a bottle, Beef/Pork $7, Pork $10 +
Syringes 17 - 27¢ each
Dextrostix (for blood sugar testing at home) 40 - 70¢ each
oral agents - Micronase - .5mg 30 - 38¢ each
Lancets 4 1/2 - 5¢ each
Alcohol wipes 3¢ each
Glucagon $20/kit
Urine Ketone Testing 10¢ each test

Monthly minimum maintenance expense:
a) 2 shots/day, blood sugars only 3 days/wk = $71.25/mo.
b) oral agent (micronase), blood sugars only 3 days/wk. = $87.55/mo.

Start up equipment:

Blood Sugar Machine and accessories	$279.00
Scale to weigh food	$ 24.00
Initial supply costs:	
Insulin, Syringes, Alcohol wipes, glucagon, Urine testing equipment.	$374.55
	$653.79

These costs do not include any expenses for nutrition books or instructions on how to use the equipment or any exercise equipment or supplies to treat insulin reactions.

If the insulin pump is necessary, costs increase by $50 - 75/month. This covers supplies such as; insulin pump tubing, syringes, op-site, and supplies for more frequent blood sugar testing.

Initial cost for start-up testing and equipment is $1295 to $2750 - exclusive of physician and health care team services and hospital expenses.

Minimum expenses for the person with diabetes on an insulin pump would be $121.25 to 146.25 per month.

People without insurance are often highly motivated to enroll in a diabetes course that teaches self management with insulin adjustment, dietary and exercise changes done by the individual themselves. This is an attempt by the individual or family with diabetes to reduce health care costs for the future and prevent loss of productive time at work or school.

In a recent quarterly review of patients participating in our 35 hour self management program, 18% of the 150 participants had no insurance what-so-ever. The national statistics quoted from the American Diabetes Association office in New York indicate that 5-8% of those people with diabetes have no health insurance. Why are our statistics higher? We don't know. Are there more people with diabetes in Kansas who can't get health insurance? Or are people trying to avail themselves of as much knowledge as possible to manage their diabetes themselves with infrequent out-patient support and reduce future medical costs?

Whatever the reason, people with diabetes bear a terrific burden in addition to the emotional impact and daily struggles to try to get food, insulin or pills and exercise to balance so the blood sugars will be near normal limits. Pregnancy, growth spurt, stress and other medications are but a few of the unplanned hazards that make blood sugars in diabetes so difficult to control.

The person with diabetes deserves the right to reasonably priced health insurance, as do other productive citizens.

We thank you for drafting this bill and we do indeed support its passage.

Respectfully Submitted,

Deborah Hinnen, R.N., M.N.
President
American Diabetes Association - Kansas Affiliate

Milly Johns -2- 12-85

Tuesday, February 12, 1985

Re: Senate Bill No. 121 - By Committee on Public Health & Welfare
Mandatory health insurance risk sharing plan.

Mr. Chairman - Members of the Senate Public Health & Welfare Committee -

I thank you for your time and consideration of the needs of Kansans for POOLED RISK HEALTH INSURANCE.

This is like "ole home week" when I see some of my friends are members of the Senate Public Health & Welfare Committee. For the rest of you, I am Mildred M. Johns (better known as Milly). I am President-Elect of the American Diabetes Association-Kansas Affiliate: Chairman of the Affiliate Public Affairs Committee: and a member of the Governmental Relations Committee of the American Diabetes Association. I am a farmer and live in Stanton County with my husband, Julius.

I GREATLY SUPPORT SENATE BILL NO. 121-There is not time for me tell you of all the reasons and needs for this mandatory legislation. What better place to start with a sharing plan than right here with this committee.

January 21 & 22, 1985, I attended the LEGISLATIVE CONFERENCE ON HUMAN SERVICES held in Topeka. I participated in the HEALTH CARE COALITION GROUP WORKSHOP. A priority need of Kansans in Health Care was POOLED RISK HEALTH INSURANCE. This priority was strongly supported by this group and later presented to the Governor's Cabinet during summarization session.

I want to tell you of some cases:
Mrs. H. has no coverage at all. She has been called on by many insurance salesmen that won't even try to write up a policy for her. She could not pay the premiums part of the time without much sacrifice and her families income was too high for medicade.

Mr. & Mrs. G. Finally found a salesman that assured them that if they took out a policy with his company that the diabetic son would be covered after one year. This was tape recorded. They paid premiums for 16 months on a family policy. After about 13 months and not hearing from the Company, they pressured the company for proof that the diabetic son was covered in their family health policy. The answer they finally got was that the diabetic son was not covered now and never would be by their company. They dropped the policy and Mrs. G. went to work at a federal paid job and this family of 4 is now covered.

Mrs. A & Mrs. B were employed in the same office of Company C. The company changed from Blue Cross/Blue Shield when there was a high increase in premiums to a different health insurance provider company for their employees. Mrs. A is a diabetic and Mrs. B was recovering from a heart attack. Mrs. A was refused coverage by the new provider. Mrs. B was covered with no riders whatever. Mrs. A called the Kansas Diabetes Affiliate office in a frantic plea for help & suggestions.

Mr. E & Mrs. J are from families that have been charter members of the Farm Bureau group of Blue Cross/Blue Shield of some 40 years. Last Fall when this group was having their family policies recontracted, Mrs. J signed for the Farm Bureau non-group and did not have to fill out a medical report. This Farm Bureau non-group coverage with BC/BS carried a higher premium but Mrs. J had no riders on the family policy. Mr. E has been in such normal level of Blood Sugar control that he did not hesitate to sign for the lower premium and to fill out the medical record form. Much to his surprise, the family policy returned with riders. He sent a request for removal of the riders. He received a letter from BC/BS Customer Service Center stating that he was given individual consideration by the Medical Review Committee of Physicians. "Based on the medical information received, the committee determined that the restrictions were correctly assigned & must remain part of the contract. However, if there is no recurrence of the conditions which necessitated the restrictions, it will not affect your membership in any way." Mr. E returned the contract and went to the Farm Bureau non-group for the family health insurance coverage with BC/BS.

Family B has one family member with Epilepsy and has had several claims covered by the company group health insurance provider. Now this family is being pressured to drop from the group or all of the group will have to pay higher premiums.

Thank you for your attention. I hope you will support this Bill No. 121 and vote for the passage of mandatory health insurance risk sharing plan.

Richard Guthrie, MD
2-12-85

Diabetes Mellitus is a chronic disease in which there is a lack of, inefficient supply of, or ineffective availability of the hormone called insulin. Insulins basic purposes are to get glucose into the cell for energy, amino acids into the cells for the process of protein synthesis (making new tissue) and to prevent the mobilization of fats. When an insulin problem occurs, glucose is left in the blood stream in an imbalance that results in varied problems that may lead to blindness, kidney failure, amputation, and other devastating physical changes. With proper medical management, that includes dietary planning, education, acitivity planning and, dpending on the type of diabetes, medication, blood glucose levels may be controlled. This outcome results in the delay and/or prevention of the complications that can be associated with this disease.

In October, 1984, a National working conference was held at Arlie, House, Virginia specifically to look at the means of financing quality health care for persons with diabetes. A summary of the findings to date were: there are an estimated 5.5 million people known to have diabetes in the United States; from statistical analysis, there are perhaps 5.5 million more people who have the disease but, as yet, have not been diagnosed. Dr. Karl Sussman, President of the American Diabetes Association stated that there were over 300,000 deaths annually attributed to diabetes; the usage of 25 million hospital days and nearly $8 billion in direct medical expenditures. He went on to reveal that with good diabetes control, i.e. keeping blood sugars as normal as possible, 60% of diabetes blindness, 50% of amputations caused by the diabetes damage that might result from poor control, and 70% of congenital malformations in infants of diabetic mothers could be prevented. He continued, stating that "...with effective patient education, hospitalizations and emergency room visits can be reduced up to 50%."

People with insulin dependent diabetes, and less so those individuals who are classified as having non insulin dependent diabetes, are generally considered as substandard insurance risks because of the high rate of complications and high rate of hospitalizations and charged an extra premium if they are covered by an insurance company at all. If the individual has developed complications from the disease, they might be rejected for insurance. The other factors that increased the ratings are the younger diabetics who have the potential of having the disease over a longer span of time and, parallel to this, the individuals actually having the disease over many years. Additive risks are hypertension, obesity and the presence of protein in the urine, indicating that kidney involvement has occurred. Retinopathy (eye damage) also adds to the unfavorable outcome of the person applying for coverage. These complications all add to lowered expected lifetimes resulting in the conclusions that insurance companies reach -that they do not wish to insure them. It was interesting to read the results of a study by the Equitable Life Insurance Company demonstrating a more favorable outcome for those whose diabetes was well controlled. If a company will insure someone with diabetes at all, there is usually, besides the extra premium, an extra waiting time sometimes as long as two years.

One of the ironies of quality diabetes care, is that the provisor for quality care will lead to the prevention and/or delay of vascular and neurological problems often associated with this disease thus reducing hospitalization for the complication and reducing medical care costs. In Maine a pilot study conducted with the State Health Department and Insurance industry showed that patient education and quality care as provided by proper insurance coverage could save $30 million per year in that State alone in health care costs. It was reported that approximately "...5 to 8% of all

persons with diabetes have no health insurance and this figure is even higher for persons under 65 and other selected groups." The reasons listed for this population not having insurance were their "poor health status, and affordability, and availability..." of an insurance program. Yet having insurance will facilitate quality care that reduces health care and insurance costs. Certainly such coverage will reduce the number of persons on Medicaid and reduce the states health care costs.

The following seven states currently have some type of high risk pool for health insurance coverage: Connecticut, Florida, Indiana, North Dakota, Minnesota, Rhode Island, and Wisconsin. Other states that are considering pooled risk insurance are California, Mississippi, Missouri, Nebraska, and Ohio. Please refer to Tables listed as 16 and 17 on the structure of such pools and Table 18 as listing the funding mechanisms for each of these state's pooled risk program. These programs give some relief to the individuals who previously did not have access to adequate insurance coverage and, prior to such coverage, had to pay medical care expenses approximately three times greater than for the person without diabetes.

Although it is recognized that if one's medical condition is good, having diabetes mellitus, the chances of getting health insurance does improve. For many, this chance is not a viable option - that is they have complications of diabetes to the point where even good control may not reverse the damage that has already been done. With quality care, there is still the possibility, where the reversal of damage may have been possible even a few years earlier, to at least slow the progression of the disease and perhaps, even give a sense of feeling better. We are tyring to educate our population as to types of insurance and how to apply for insurance, Medicare and Medicaid. When all avenues have been attempted, these people without the assistance of some

pooled risk program, are in trouble. As noted by the previous information, poor quality care will lead to more devasting problems associated with the disease. Help us in our fight to assist these people to attain and maintain a better level of health, if for no other reason than to decrease the cost of health care, both for them and for their family and, ironically, for society and for the insurance companies. In the decisions soon to be made, please assist in returning people who have diabetes to an active life in society. Allow them to join the other 186 million or 8 out of 10 Americans which are covered by major medical expense policies. Let us overcome this one other avenue of discrimination and allow the presently uninsurable the quality of health care they so rightly deserve.

Thank you.

Richard A. Guthrie, M.D.
Executive Director
Kansas Regional Diabetes Center

	Minnesota	Florida	Connecticut	North Dakota	MODEL	Montana
Pre-existing Conditions	6 months if condition treated in past 90 days	12 months if manifested in past 6 months	12 months if manifested in past 6 months	6 months if diagnosed in previous 90 days	12 months if condition occurred in previous 6 months	1 year if condition occurred in previous 5 years
Maximum Lifetime Benefits	250,000	500,000	1,000,000	250,000	1,000,000	100,000
Perscription Drugs	Yes	Yes	Yes	Depends on plan	Yes	No
Premium	125%	200%	Re-calculated every year. Comparable to normal rates	135%	200%	400%
Rental/Purchase Medical Equipment	Yes	Yes	Rental only	Depends on plan	Rental only	($1000.00) 50% of rental or purchase price
Health Association	7 member Board elected by All Insurers, Self-Insurers & Health Maintenance Organizations	Assoc of All Insurers 7 mem Board-Committee 3 members appt'd by Ins Commissioners 1 from Gen Public 1 Rep of Med Providers 1 Rep Health Ins Agts 4 Members by participating Insurers	Insurance Commission	10 Ins. Indv. from participating Insurers	All Insurers with Board of Directors approved by Commissioners	7 Board Members from Insurance Assoc 1 Physician ?
Deduct	$500/1000	1000/1500/2000	$200/500/750	$1000/500/150	$500/1500	$1000
Nursing Home	120 days per year	120 days per year	Yes	Depends on plan	270 days per year	No
Home Health	Yes	Yes	Yes	Depends on plan	270 days per year	180 visits per year
Referral Fee	$50.00	--------	----------	----------	----------	$25.00
Gains/Losses Administrative Costs	Shared by Assoc. members	Shared by Assoc. members		Shared by Assoc. members	Shared by Assoc. members	Shared by Assoc. members

TABLE 16

ORGANIZATION OF CURRENTLY OPERATING
STATE HEALTH INSURANCE RISK POOLS

State	Name of Pool	Effective Date	Administrator	Participation	Current Enrollment
Connecticut	Health Reinsurance Association Plan	April 1, 1976	Travelers	All insurance companies in state	4,000 (December 1982)
Florida	Comprehensive Health Insurance Plan	October 1983	Gulf Life insurance company	All insurance carriers in the state	67 (Feb. 1984)
Indiana	Comprehensive Health Insurance Association (ICHIA)	May, 1982	Mutual of Omaha	All insurance carriers in the state	2,000 (December, 1983)
Minnesota	Comprehensive Health Association	June, 1977	Blue Cross/ Blue Shield	All licensed health insurance carriers in the state	6,000 (December, 1983)
North Dakota	Comprehensive Health Association (CHAND)	January 1, 1982	Blue Cross/ Blue Shield	All health insurance carriers	400 (May, 1984)
Rhode Island	Facility Reinsurance Pool	January 1975	State	All health insurance carriers except BC/BS	Less than 20 (January, 1984)
Wisconsin	Health Insurance Risk Sharing Plan	July 1, 1981	Mutual of Omaha	All health insurance carriers	1,600 (December, 1983)

Source: Data compiled by the Texas State Board of Insurance, Research and Information Services Division, 1984.

TABLE 17

STRUCTURE OF CURRENTLY OPERATING STATE HEALTH INSURANCE RISK POOLS

State	Pool Deductibles	Premium Caps	Stop Loss: Individual	Stop Loss: Family	Coverage Limit	Pre-existing Condition Restricted Coverage:
Connecticut	$200 $500 $750	Minimum: 125% Minimum: 150%	$ 1,000	$2,000	$1,000,000	None
Florida	Plan I $1,000 Plan II $1,500 Plan III $2,000	Initial: 150% Maximum: 200%	Plan I: $2,500 Plan II: $3,000 Plan III: $3,500	 $4,000 $4,500 $5,000	$ 500,000	12 months
Indiana	$200 $500 $1,000	Maximum: 150%	$1,000	$2,000		6 months
Minnesota	$150 $500 $1,000	Maximum: 125%	$3,000	----	$250,000	6 months
North Dakota	$150 $500 $1,000	Maximum: 135%	$3,000	----	$250,000	6 months
Rhode Island	$100	NA	NA	NA	NA	12 months
Wisconsin	$1,000	Maximum: 150%	$2,000	$4,000	$250,000	6 months

Source: Data compiled by the Texas State Board of Insurance, Research and Information Services Division, 1984.

TABLE 18

FUNDING MECHANISMS FOR STATE
HEALTH INSURANCE RISK POOLS

State	Source
Connecticut	Assessment of losses to participating insurers
Florida	Assessment with credit applied against premium tax and income tax. Maximum assessment of 1% per year on premium or greater than premium tax. Use formula of approximately 20% per year offset.
Indiana	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
Minnesota	Assessment with credit applied against premium tax and income tax.
North Dakota	Assessment of losses to participating insurers
Rhode Island	No information available
Wisconsin	Assessment of losses to participating insurers

Source: A. Trippler, Status of Legislation Creating Catastrophic Health Insurance Pools and a Comparison of Five State Plans. (Fergus Falls, Minnesota: Communicating for Agriculture, July 1, 1984).